

NANCY L. JOHNSON, CONNECTICUT, CHAIRMAN
SUBCOMMITTEE ON HEALTH

JIM McCRERY, LOUISIANA
PHILIP M. CRANE, ILLINOIS
SAM JOHNSON, TEXAS
DAVE CAMP, MICHIGAN
JIM RAMSTAD, MINNESOTA
PHIL ENGLISH, PENNSYLVANIA
KENNIFER DUNN, WASHINGTON

TNEY PETE STARK, CALIFORNIA
RALD D. KLECZKA, WISCONSIN
JOHN LEWIS, GEORGIA
JIM McDERMOTT, WASHINGTON
LLOYD DOGGETT, TEXAS

EX OFFICIO:
BILL THOMAS, CALIFORNIA
CHARLES B. RANGEL, NEW YORK

BILL THOMAS, CALIFORNIA, CHAIRMAN
COMMITTEE ON WAYS AND MEANS

ALLISON H. GILES, CHIEF OF STAFF
JOEL C. WHITE, SUBCOMMITTEE STAFF DIRECTOR

JANICE MAYS, MINORITY CHIEF COUNSEL
CYBELE BJORKLUND, SUBCOMMITTEE MINORITY

Congress of the United States

U.S. House of Representatives

COMMITTEE ON WAYS AND MEANS

WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

August 2, 2004

Protecting the Pocketbooks of Cancer Patients and Access to Cancer Care

Dear Colleague:

Congress significantly reformed the way Medicare pays for physician-administered drugs in the *Medicare Prescription Drug, Improvement, and Modernization Act* (MMA). Medicare will now pay real market rates for drugs and provide fair reimbursement for oncologists and others to administer the drugs. On July 27th, the Centers for Medicare & Medicaid Services (CMS) published its proposed rule to implement these changes.

CMS is currently in a 60-day comment period on the proposed rule. Only after the review of drug administration codes has concluded and a final rule has been issued, we will then be able to evaluate both the accuracy of the new drug pricing mechanism and the accuracy of the new drug administration payments. Any analysis up until that point is purely speculative. The physician community is currently providing extensive critical cost data to the process, with continued openness and good will. I believe we can agree on a more accurate payment system, with considerably lower co-payments for seniors. An update on the proposed regulations follows.

Overpayments "Tax" Patients

- Often times, Medicare pays significantly more for Part B drugs than the physicians who purchase the drugs – a difference known as the "spread." Physicians have been using some or all of the spread to cover the cost of administering drugs.
- According to the General Accounting Office (GAO) and CMS, Medicare overpaid for Part B drugs by over \$1 billion in 2001. In 2002, oncologists collected approximately \$600 million in overpayments. The GAO, the Department of Health and Human Services' Office of Inspector General (OIG), and MedPAC concluded that the pre-MMA system for reimbursing Part B drugs was seriously flawed and inflationary.
- These overpayments "tax" patients who must pay a 20% coinsurance on the inflated Medicare payment for the drug. The OIG estimated that in 2000, Medicare beneficiaries paid \$177 million in unnecessarily inflated co-payments for physician-administered drugs. In fact, there are many cases where seniors' coinsurance payments for a drug were higher than what the physician paid!

The oncology community agrees that the reforms effective this year have not restricted access to care.

- As mandated by MMA, the average payment for cancer drug administration has increased permanently by 110%. The bill required CMS to include a factor for physician work,

oncology nurse costs, multiple pushes, and the oncologists' own cost data, thus guaranteeing a permanent significant increase. MMA also included a transitional payment in 2004 that increases these practice expense payments by an additional 32%.

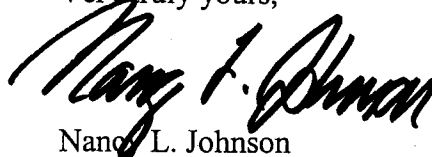
- While reimbursements for drugs were reduced in 2004 to make Medicare's payments more accurate, the Congressional Budget Office estimated Medicare's total reimbursements to oncologists for drugs and their delivery would increase by \$100 million from 2003 to 2004.

Issues for 2005 and thereafter:

- Physicians will be paid 6% more than the "average sales price" (ASP) for the drug, which is the average price at which drugs are actually sold, rather than an inflated "list" price. Based on preliminary ASP data, CMS estimates that Medicare payments to oncologists for drugs would decline by 8% overall in 2005. Because ASP data are updated quarterly through manufacturers' reports, ASP rates will change before implementation in January 2005. These reduced, and more accurate, reimbursements for drugs will lower beneficiary cost sharing significantly.
- Base payments for drug administration will remain 110% higher than in 2003. While the additional transition payment will decrease from 32% to 3%, it will largely be replaced by new payment codes and increased payments under existing payment codes for drug administration. These codes are being developed this year and will increase payments to oncologists.
- In February, the American Medical Association (AMA) convened a workgroup to examine the issue of physician drug administration, as the law requires. This workgroup has received very detailed and comprehensive input from outside stakeholders, including a report from oncology practice managers. I am encouraged by the inclusive nature of this process and reports of their progress.
- CMS projects that total Medicare payments to oncologists, for both drugs and drug administration, will decline between 2% and 8% from 2004 to 2005. Actual payments for cancer care will differ from these estimates as a result of changes to: ASP for cancer care drugs; payments for drug administration based on the AMA review; and utilization.
- CMS projects that Medicare beneficiaries will save \$480 million in fiscal year 2005 as a result of MMA reforms to pay real market rates for drugs and provide fair reimbursement for drug administration, including reforms for non-cancer and inhalation drugs.

Our shared goal is to guarantee that no patient is denied access to high-quality cancer care. I will continue to monitor implementation of the law to ensure that this is the case. For more information, please contact Madeleine Smith with the Ways and Means Health Subcommittee at x53943.

Very truly yours,



Nancy L. Johnson
Chairman, Subcommittee on Health